CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 530 SERVICE LIMITS, CO-PAYMENTS, AND NON-COVERED SERVICES

Readopt with amendment He-W 530.01, effective 3-12-08 (Document #9103), as amended effective 7-1-12 (Document #10139), to read as follows:

He-W 530.01 Definitions.

(a) "Co-payment" means an amount to be paid by the recipient to an enrolled New Hampshire medicaid provider.

(b) "Department" means the New Hampshire department of health and human services.

(c) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or the recommendations of physician specialists practicing in relevant clinical areas or of various physician specialty societies.

(d) "Medicaid" means the Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.

(e) "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

(1) Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

(2) Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

(3) No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

(4) Not experimental, investigative, cosmetic, or duplicative in nature.

(f) "Multi-source pharmaceutical product" means a product which is available from more than one manufacturer.

(g) "Non-preferred prescription drug" means a medication that has been determined to have an alternative drug available that is clinically equivalent and has been clinically reviewed and approved by the NH Pharmacy and Therapeutics Committee or the NH Drug Use Review Board established in He-C 5010 and has been included on the department's preferred drug list as non-preferred.

(h) "Preferred prescription drug" means a medication that has been clinically reviewed and approved by the NH Pharmacy and Therapeutics Committee or the NH Drug Use Review Board

established in He-C 5010 and has been included in the department's Preferred Drug List based on its proven clinical and cost effectiveness.

(i) "Preferred Drug List (PDL)" means a formal published list of specific prescription drug products by brand and generic name divided into 2 separate categories as either preferred or non-preferred.

(j) "Provider" means an entity or individual who furnishes health care services or supplies to medicaid recipients under an agreement with the department, and is licensed or certified pursuant to applicable state law to provide such services and supplies.

(k) "Recipient" means any individual who is eligible for and receiving medical assistance under the medicaid program.

(l) "Service" means medical care or a medical product for which payment is made by New Hampshire medicaid.

(m) "Service limit" means a finite number of visits or units of service per recipient per specified time period for which payment is made by New Hampshire medicaid.

(n) "Single source pharmaceutical product" means a brand name product which is available from only one manufacturer.

(o) "State fiscal year" means July 1 through June 30.

(p) "Third party entity" means the agency under contract with the department to collect and process premium payments for medicaid recipients.

(q) "Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(r) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(s) "Unit" means a determinate quantity for which a particular service is rendered.

(t) "Visit" means all services provided to a recipient per appointment or encounter with a provider.

Readopt with amendment He-W 530.02, effective 8-26-15 (Document #10915), to read as follows:

He-W 530.02 Recipients Subject to Service Limits, Co-Payments, and Non-Covered Services.

(a) All recipients shall be subject to service limits in accordance with He-W 530.03.

(b) All recipients shall be subject to the co-payments specified in He-W 530.04, except for:

(1) Recipients with income at or below 100% of the federal poverty level (FPL);

(2) Recipients residing in a nursing facility, hospital, intermediate care facility for individuals with intellectual disabilities, or other medical institution;

(3) Recipients participating in the home and community based care (HCBC) waiver programs;

(4) Recipients receiving services that relate to pregnancy, in accordance with 42 CFR 447.53(b)(2), or any other medical condition that might complicate the pregnancy;

(5) Recipients under the age of 18;

(6) Women eligible through the Breast and Cervical Cancer Treatment Program, pursuant to 42 CFR 435.213;

(7) Recipients receiving hospice care pursuant to He-W 544~~.~~; and

(8) Individuals who are members of a federally recognized Indian tribe or Alaskan natives who have ever been served through the Indian Health Services Programs, pursuant to 42 CFR 447.56(a)(x).

(c) All recipients shall be subject to non-covered services provisions in accordance with He-W 530.05.

Readopt with amendment He-W 530.04, effective 11/18/14 (Document #10716,) to read as follows:

He-W 530.04 Co-Payments.

(a) Recipients subject to co-payments shall make co-payments to the pharmacy provider for pharmaceutical products as follows, except as noted in (3) below:

(1) For recipients eligible for medicaid through the New Hampshire Health Protection Program (NHHPP) co-payments as required in He-W 512.~~:~~

~~a. A co-payment in the amount of $4.00 shall be required for each preferred prescription drug and each refill of a preferred prescription drug dispensed; and~~

~~b. A co-payment in the amount of $8.00 shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug dispensed unless the prescribing provider determines that a preferred prescription drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case the co-payment for the non-preferred prescription drug shall be $4.00; and~~

~~c. A co-payment in the amount of $4.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug;~~

(2) For all other recipients subject to co-payments as required by this part:

a. A co-payment in the amount of $14.00 shall be required for each preferred prescription drug and each refill of a preferred prescription drug dispensed;

b. A co-payment in the amount of $28.00 shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug dispensed unless the prescribing provider determines that a preferred drug will be less effective for the

recipient, will have adverse effects for the recipient, or both, in which case, the co-payment shall be $14.00; and

c. A co-payment in the amount of $14.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug; and

(3) Co-payments for pharmaceutical products shall not be required:

a. Of recipients exempt from co-payments in accordance with He-W 530.02(b);

b. For family planning products; and

c. For Clozaril (Clozapine) prescriptions.

(b) Recipients subject to co-payments shall make co-payments to the provider for services as follows, except as noted in (23) below:

(1) For recipients eligible for medicaid through the NHHPP, co-payments as described in He-W 512~~(2) below and the following co-payments:~~; and

~~a. A co-payment in the amount of $125 for each inpatient substance use disorder treatment admission; and~~

~~b. A co-payment in the amount of $3.00 for each chiropractor visit;~~

~~(2) All other recipients shall make co-payments to providers as follows:~~

~~a. A co-payment in the amount of $125 for each inpatient mental health admission, or hospital admission, excluding maternity admissions;~~

~~b. A co-payment in the amount of $125 for each inpatient hospital admission, excluding maternity admissions;~~

~~c. A co-payment in the amount of $35 for high-cost imaging such as CT/PET scans and MRIs;~~

~~d. A co-payment in the amount of $3.00 for each visit as follows:~~

~~1. Primary care provider visit;~~

~~2. Behavioral health outpatient visit;~~

~~3. Physical therapy visit;~~

~~4. Occupational therapy visit; and~~

~~5. Other medical professional visit to other medical professional such as an advanced practice registered nurse or a physician's assistant; and~~

~~e. A co-payment in the amount of $8.00 for each visit as follows:~~

~~1. Physician specialist visit; and~~

~~2. Speech therapy visit; and~~

(2~~3~~) Recipients shall not be responsible for a co-payment for the following services:

a. Emergency services needed to evaluate or stabilize an emergency medical condition as defined in 42 CFR 438.114(a);

b. Provider-preventable services as described in 42 CFR §447.26(b);

c. Services furnished to pregnant women, including counseling and pharmacotherapy for cessation of tobacco use;

d. Family planning services and supplies; and

e. Preventive services.

(c) Pursuant to 42 CFR 447.56(f), co-payment obligations shall be suspended for the remainder of the calendar year quarter when the total co-payments made out of pocket by the recipient reaches 5 percent of the recipient's household income.

(d) All recipients subject to co-payments required by this part shall not be denied services by any medicaid enrolled provider on account of the recipient's inability to pay the co-payments required by this part.

Amend He-W 530.07(e), (f)(2), (h), (i), (m) and (n) effective 5-23-14 (Document #10605), so that (e), (f) intro, (f)(2), (h), (i), (m), and (n) are cited and read as follows:

He-W 530.07 Prior Authorization of Services Which Exceed Service Limits.

(e) Providers shall direct requests for prior authorization of services in excess of the limits described in He-W 530.03 to the department.

(f) Prior to payment by the department, requests for prior authorization of covered services in excess of the limits described in He-W 530.03 shall:

(2) Be submitted in writing to the department via mail, e-mail or fax;

(h) Except as allowed by He-W 573.10, prior authorization requested in accordance with (b) through (g) above shall be approved by the department if the department determines that the requested additional services meet the definition of medically necessary or that coverage is supported by clinical documentation provided in accordance with (g)(8) above.

(i) If the department approves the prior authorization request in accordance with (h) above, the state's fiscal agent shall send written confirmation of the approval to the provider.

(m) Except as allowed by He-W 573.10, the department shall deny a prior authorization request when the department determines that the requested additional services do not meet the definition of medically necessary and that the coverage is not supported by clinical documentation provided in accordance with (g)(8) or (9) above.

(n) If the department denies the prior authorization request, the department shall forward a notice of denial to the recipient and the wheelchair van provider.

Amend He-W 570.01, effective 12-21-10 (Document #9831), as amended effective 7-1-12 (Document #10139), by inserting new paragraphs (s), (z), and (aa) and renumbering subsequent paragraphs, so that (s), (z), and (aa) are cited and to read as follows:

PART He-W 570 PHARMACEUTICAL SERVICES

He-W 570.01 Definitions.

(s) "Non-preferred prescription drug" means a medication that has been determined to have an alternative drug available that is clinically equivalent and has been clinically reviewed and approved by the NH Pharmacy and Therapeutics Committee or the NH Drug Use Review Board established in He-C 5010 and has been included on the department's preferred drug list as non-preferred.

(z) "Preferred prescription drug" means a medication that has been clinically reviewed and approved by the NH Pharmacy and Therapeutics Committee or the NH Drug Use Review Board established in He-C 5010 and has been included in the department's Preferred Drug List based on its proven clinical and cost effectiveness.

(aa) "Preferred Drug List (PDL)" means a formal published list of specific prescription drug products by brand and generic name divided into 2 separate categories as either preferred or non-preferred.

Readopt with amendment He-W 570.13, effective 11-18-14 (Document #10716), to read as follows:

He-W 570.13 Prescription Co-payment.

(a) Recipients shall make co-payments to the pharmaceutical provider for pharmaceutical products as follows, except as set forth in (b) below:

(1) For recipients eligible for medicaid through the New Hampshire Health Protection Program (NHHPP) co-payments as required in He-W 512~~:~~; and

~~a. A co-payment in the amount of $4.00 shall be required for preferred prescription drug and each refill of a preferred prescription drug dispensed;~~

~~b. A co-payment in the amount of $8.00 shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug dispensed unless the prescribing provider determines that a preferred prescription drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case the co-payment shall be $4.00; and~~

~~c. A co-payment in the amount of $4.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug.~~

(2) For all other recipients:

a. A co-payment in the amount of $14.00 shall be required for each preferred prescription drug and each refill of a preferred prescription drug dispensed;

b. A co-payment in the amount of $28.00 shall be required for each non-preferred prescription drug and each refill of a non-preferred prescription drug dispensed unless the prescribing provider determines that a preferred prescription drug will be less effective for the recipient, will have adverse effects for the recipient, or both, in which case the co-payment shall be $24.00; and

c. A co-payment in the amount of $14.00 shall be required for a prescription drug that is not identified as either a preferred or non-preferred prescription drug.

(b) Co-payments for pharmaceutical products shall not be required:

(1) Of recipients with income at or below 100% of the federal poverty level (FPL);

(2) Of recipients in a nursing facility, hospital, intermediate care facility for individuals with intellectual disabilities, or other medical institution;

(3) Of recipients participating in the home and community based care (HCBC) waiver programs;

(4) Of recipients receiving services that relate to pregnancy in accordance with 42 CFR 447.53 (b)(2), or any other medical condition that might complicate the pregnancy;

(5) Of recipients under the age of 18;

(6) For family planning products;

(7) For Clozaril (Clozapine) prescriptions;

(8) Of women eligible through the Breast and Cervical Cancer Treatment Program, pursuant to 42 CFR 435.213;

(9) Of recipients receiving hospice care pursuant to He-W 544; and

(10) Of individuals who are members of a federally recognized Indian tribe or Alaskan natives who have ever been served through the Indian Health Services Program, pursuant to 42 CFR 447.56(a)(x).

APPENDIX B

RULE	STATE OR FEDERAL STATUTE THE RULE IMPLEMENTS
He-W 530.01	RSA 318:1; 21 CFR 310.6; 42 CFR 440.120; 21 USC 802(6), 42 CFR 447.53; 42 CFR 456 subpart K; Chapter Law 188 and 281:9, 2004, SB 383-FN, 2004.
He-W 530.02	42 USC 1396o; 42 CFR 447.53, 42 CFR 447.56
He-W 530.04	42 USC 1396o; 42 CFR 447.53, 42 CFR 438.114(a), 42 CFR 447.26(b), 42 CFR 447.56
He-W 530.07(e), (f) intro & (2), (h), (i), (m) and (n)	42 CFR 440.230(d); 42 CFR 431.107; RSA 126-A:5, VII
He-W 570.01(s), (z), (aa)	RSA 318:1, VII; RSA 318:1, XV, RSA 318:1, XVI, RSA 318:21; RSA 126-A:3, III(b), 21CFR 310.6, 42 CFR 440.120, 42 CFR 447.53; 42 CFR 456 subpart K; Chapter 188 and 281:9, 2004, SB 383-FN, 2004
He-W 570.13	42 USC 1396o; 42 CFR 447.53, 42 CFR 447.56